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G90-975 Health Insurance for Older People (Revised February 1991)

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Health Insurance for Older People

This guide discusses basic Medicare benefits on private health insurance, commonly called Medigap insurance, available to supplement Medicare.

Kathy Prochaska-Cue--Extension Family Economics and Management Specialist

Medicare

What are the two parts of Medicare?

1. **Medicare Part A -- Hospital Benefits.** This pays for your care while you are in the hospital, and for related health services after you leave the hospital, including necessary care in a Medicare approved nursing home.
2. **Medicare Part B -- Medical Insurance.** This helps pay doctor bills and hospital out-patient expenses.

How much does Medicare pay when I have a claim?

Medicare requires each individual to pay some expenses under Parts A and B*. The amounts left for you to pay may change periodically; 1991 figures are shown.

1. **Hospital.** Medicare Part A pays for a semi-private room and all necessary and reasonable hospital expenses for the **first 60 days in a benefit period**, except for \$628. From the 61st through the 90th day in a benefit period, Medicare pays all covered services **except for \$157 per day**.

A benefit period is a way of measuring your use of services under Medicare Part A. The first benefit period starts the first time you enter a hospital. When you have been out of a hospital or skilled nursing home for 60 days in a row, a new benefit period begins the next time you go into a hospital.

There is no limit to the number of benefit periods you can have.

Should an illness require more than 90 days of hospitalization, Medicare Part A includes 60 additional **reserve days** during which it pays covered hospital charges **except for \$314 a day**. Once you use a reserve day you never get it back. Reserve days are not renewable like your 90 hospital days.

2. **Nursing Home.** Medicare Part A helps pay for approved inpatient care in a Medicare-approved skilled nursing home following hospitalization. In each benefit period it pays for reasonable costs for all covered services for the first 20 days you are in a skilled nursing facility. After 20 days, it pays for all covered services for the **21st through 100th day, except for \$78.50 a day**. These benefits are only payable if: (a) your physician certifies need for such care; (b) you are receiving skilled services that can

be provided as an inpatient in a skilled nursing facility; (c) confinement follows a minimum three-day hospital stay; (d) confinement is for further treatment of the condition treated in the hospital; (e) admitted to the nursing facility within 30 days after hospital discharge; (f) the nursing facility is Medicare-certified; and (g) the stay is approved by the facility's Utilization Review Committee or Peer Review Organization.

3. **Home Health Care.** Medicare Part A provides for home nursing visits by skilled paramedical personnel. These benefits can include physical or speech therapy, skilled medical services, occupational therapy if also in need of physical or speech therapy, and supplies and equipment provided by certified home health care agencies.
4. **Hospice Care.** Under certain conditions, Medicare Part A pays for a lifetime maximum of two 90-day hospice benefit periods and one 30-day period. During a hospice benefit period, Part A pays the full cost of all covered medical and support services necessary for the symptom management and pain relief of a terminal illness. Co-payments are required for outpatient drugs and inpatient respite care.
5. **Mammography.** Mammograms at least once every two years are covered for women age 65 and older.
6. **Medical Expenses.** Medicare Part B requires you to **pay \$100 of your doctor's charges in each calendar year**. After you have paid the \$100 deductible amount, the program will pay for 80 percent of reasonable medical charges; you are responsible for the remaining 20 percent of those charges.

The key word is "reasonable." Medicare determines what is a reasonable charge. It could be considerably below a doctor's normal fee.

Some doctors accept that figure, but others do not. If your doctor is willing to accept a Medicare assignment, that is, accept Medicare's determination of a reasonable charge, your out-of-pocket expense will be 20 percent of the doctor's charges. If not, your out-of-pocket expense will be the 20 percent coinsurance and that part of the doctor's charges in excess of Medicare's definition of reasonable.

What are some of the expenses Medicare does not cover?

1. Private room charges in a hospital unless medically necessary.
2. Out-of-hospital prescription drugs.
3. Private duty nurses.
4. Routine physical checkups, eye exams, dental care, hearing exams.
5. Skilled nursing home care costs (beyond what is covered by Medicare).
6. Intermediate nursing home care costs.
7. **Custodial care** in a hospital or nursing home. Care is considered custodial when it is primarily for the purpose of meeting your personal needs and could be provided by persons without professional skills or training; for example, help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine.
8. Doctor's charges above Medicare's approved amount.
9. Most care received outside the United States.
10. The first three pints of blood you receive in a benefit period.

Medicare Supplement Insurance

There are no set standards as to the type and extent of private insurance which should be obtained to supplement Medicare benefits. You must judge for yourself what your health insurance needs are and how much you can afford to pay for such insurance.

Before purchasing a Medicare supplement policy, several factors should be considered.

1. **Do you understand your Medicare coverage?**

A complete Medicare handbook is available at your local Social Security Office, where there are people available to answer your questions.

2. **Can you afford the premium payments of a Medicare supplement policy?**

Most of these policies range from \$600 to \$2,000 or more annually, depending upon the extent of coverage provided and your age.

3. **For which gaps in the Medicare program do you wish to buy coverage?**

Medicare's smaller gaps include the \$628 deductible and \$157 or \$314 copayments for a hospital stay and the \$100 deductible for medical bills. The larger gaps include long-term care in a hospital or nursing home, and the 20 percent co-payment on medical bills and out-of-hospital prescription drugs. Also, Medicare restricts nursing home benefits to "approved" facilities.

A comprehensive policy should fill in most of the larger gaps of Medicare. Hospital benefits in a Medicare supplement policy correspond to the Medicare gaps quite closely. However, medical benefits can differ greatly from one policy to another.

Some policies pay up to a maximum dollar limit for each calendar year; others provide unlimited coverage. Most policies pay medical benefits on a percentage basis, that is, the 20 percent copayment after Medicare pays 80 percent.

Policies also are available which pay on an "indemnity" basis. Indemnity benefits provide a set payment for each doctor's visit or for each surgical procedure.

If you are insured under a policy which pays on a percentage basis, check the contract to determine whether payment is based on the amount which Medicare considers "reasonable" or on the amount actually charged by the doctor.

As mentioned earlier, the "reasonable" charge as determined by Medicare can be considerably below a doctor's normal fee.

4. **Do you understand the coverage limits for skilled nursing homes or extended care facilities?**

Three types of nursing homes are licensed in Nebraska: Skilled, Intermediate Care Facility I and Intermediate Care Facility II. A skilled home has a licensed nurse on duty 24 hours a day.

Private insurance companies selling nursing home coverage differ as to the types of homes they will cover. Some will only cover what Medicare covers; some will pay in a Skilled Facility, whether approved by Medicare or not; and others will pay in an Intermediate Care Facility (ICF I or II). An ICFI has a registered nurse and/or licensed practical nurse on duty at least eight hours a day.

One of the most important things to look at when buying nursing home coverage is the definition in the policy of "nursing home" or "extended care facility." Does it indicate that the home has to be Medicare approved? How many hours a week must a registered nurse be on duty in order to qualify under the policy?

Ask the agent to go over the policy definition with you and ask him or her which of the homes in your area will qualify. You can confirm this information by calling or writing the home office of the insurance company.

The status of a nursing home is subject to change, so it is a good idea to recheck with the company before entering any nursing home.

Many nursing home policies specify the level of care which must be received in a qualified home before benefits will be provided. Although you may be confined in a home that meets the policy definition of nursing home, if you are not receiving the level of care specified, your claim will be denied.

5. Is there a provision in the policy which states that pre-existing conditions will not be covered for a certain length of time?

Pre-existing conditions are medical problems you have been treated for or had symptoms of within six months prior to the policy issue date. Policies often contain a provision which requires satisfaction of a six-month waiting period before pre-existing conditions are covered.

6. Do you intend to terminate some existing coverage after buying a new policy?

It is usually not to your advantage to drop one policy in favor of another policy providing similar benefits. A new waiting period for pre-existing conditions will apply. Also, depending on the benefits, the cost of the new policy may be higher because of your higher attained age. If you plan to replace the policy, the agent is required to leave a written comparison of your present policy and the one being sold.

7. How does the policy's coverage compare to any existing private health coverage you have?

It is usually not necessary to buy several policies to obtain adequate coverage. One comprehensive policy may be better than several policies which have overlapping coverage. If an agent suggests adding to your present insurance program, cautiously evaluate your need. You want adequate protection, without being overinsured. Check with family members or a trusted, knowledgeable insurance person in your community as to whether or not the purchase is desirable.

8. Can the policy be canceled at the option of the company, or is it guaranteed renewable for life?

Check under the policy heading of "Renewal Provisions" to determine this information. If the policy is guaranteed renewable, the company agrees to continue insuring you as long as you pay the premium, and as long as the company remains in business.

9. Does the application you sign contain correct personal information and all requested medical or health history?

If an agent helps you fill out the application, do not sign it unless you have read it and know that all medical information requested is included. If you omit medical information on the application and it is later brought to the attention of the insurance company, your claim may be denied and/or your policy terminated.

10. What is a Health Maintenance Organization (HMO)?

A Health Maintenance Organization is a clinic or group of doctors that provides medical services. There may be one or more HMOs in your area which participate in the Medicare program. People who join HMOs pay a membership fee, or premium, and then receive health services directly from physicians and other providers affiliated with the HMO. Services are prepaid, so there are usually no claim forms to process. For Medicare covered services, there are usually no separate charges for deductibles or co-payments.

If you are willing to receive your care from a specified group of providers, an HMO may provide the most complete service for your health care dollar. However, if you go to a doctor not associated with the HMO, except on a referral basis, you will not receive benefits from Medicare or the HMO.

When you join the HMO your Medicare benefits are assigned to the HMO. When you discontinue membership in the HMO, Medicare must be notified. If you join an HMO, you don't need other insurance.

11. What types of health insurance are available to senior citizens?

There are several types of policies senior citizens may buy in addition to their Medicare supplement and/or nursing home policy.

1. A **Hospital Indemnity** policy pays a set dollar amount for each day of hospitalization.
2. A **Medical/Surgical** policy pays a portion of doctor bills not covered by Medicare. The policy might pay a specified dollar amount, a percentage of Medicare's reasonable charge, or a percentage of the doctor's charge.
3. A **Cancer (Catastrophic Illness)** policy pays benefits only for care provided for the specific illness. Related illnesses or complications usually aren't covered.
4. **Accident Only** policies pay benefits for expenses resulting *solely* from accidents.

Policies for specific and limited needs are no substitute for Medicare supplements, HMOs or other major medical insurance for the older adult. If you have a personal reason for *also* buying this type of extra coverage, exercise caution. Read the policy carefully. Don't buy more policies than you need. Duplicate coverage is costly and unnecessary.

Important Points to Remember

1. An agent seeking to sell you Medicare supplement insurance is a representative of a private insurance company. He or she is not associated with Medicare or the federal government.
2. If you decide to buy insurance from an agent, don't pay cash or make your check payable to the agent or the agent's agency. Write your check to the insurance company and ask for a receipt showing the agent's name and address, and the name and address of the insurance company.
3. Don't let an agent pressure you into a quick decision. It may be best to postpone your buying decision until you have had a chance to talk with a trusted, knowledgeable insurance person or friend.
4. Do not rely on the agent to accurately describe your coverage. The insurance company is not bound by the agent's promises which, if incorrect, may be difficult to prove. Remember that the company will pay only the benefits provided in the insurance policy.
5. No insurance policy "pays everything Medicare does not." Find out exactly what benefits are available.
6. Shop around. Buy the coverage which meets your needs. Don't duplicate coverage. This is costly and unnecessary.
7. Before you sign the application, **READ IT**. If any medical information is omitted from the application, add it. Don't let the agent tell you it isn't needed . . . let the company decide. If pertinent medical information is not listed on the application, the company can deny the claim, void your policy and refund the premium.
8. All individual Medicare supplement policies are required to contain a clause that allows you 30 days to examine the policy following delivery to you. If you decide you don't want the coverage, you are entitled to a full refund of premium, provided the request is made to the company during the 30-day period following delivery. Following this 30-day period, a company is not obligated to refund any portion of the premium. Ask for a copy of the delivery receipt. It is wise to return the policy by certified mail.
9. State insurance law requires delivery of an outline of coverage at the time application is made for an individual Medicare supplement policy. This outline provides a brief description of the important

features of a policy. It is important to remember that the outline of coverage is not the actual contract. You must be certain to **READ YOUR POLICY CAREFULLY**.

10. Medicare benefits are now secondary to benefits payable under an employer group health plan. Companies with 20 or more employees must provide the same insurance coverage to employees age 65 through 69 and their spouses as to others. This means that medical expenses should be submitted to your group insurance carrier before they are submitted to Medicare.

How Do I File a Claim?

Make sure the claim form received from the company is completed properly. Attach a photocopy of the itemized bills and Medicare Explanation of Benefit forms. Keep the originals.

For More Information

Contact the Department of Insurance at the following address if you have any questions or problems concerning insurance:

*Nebraska Department of Insurance
Terminal Building
941 "O" Street, Suite 400
Lincoln, Nebraska, 68508
Phone (402) 471-2201*

Medicare/Medigap			
1990	What Medicare Covers	What Nebraska Law Requires of Medigaps	What Common Medigap Policies Cover
Part A			
Hospital Inpatient			
Day 1-60	all but \$628	Nothing	All or part of \$628
-- 60-90	all but \$157/day	\$157	\$157/day
-- 91-150	all but \$314/day	\$314/day	\$314/day
-- 150+	Nothing	90% of eligible expenses for one year	90% of eligible expenses for one year
Post-Hospital Skilled Nursing (Medicare Approved)			
Day 1-20	All	Nothing	Nothing
-- 21-100	All but \$78.50/day	\$78.50/day	\$78.50/day
-- 100+	Nothing	Nothing	Nothing/Some
-- Non-Medicare Approved Facility	Nothing	Nothing	Nothing/Some
Intermediate or Custodial	Nothing	Nothing	Nothing/Some
Home Health			

(Medicare approved)			
Intermittent Care	All	Nothing	Nothing
Hospice			
2 90-day benefit periods	All approved	None	Some/None
1 30-day benefit period	All approved	None	Some/None
co-payment for prescription drugs	All but 5%	None	5%/None
co-payment for respite care	All but 5%	None	5%/None
Part B*			
Medical Expenses			
Doctor's Charges	After \$100 deductible 80% of Medicare-approved charges	After \$100 deductible 20% of Medicare-approved charges	May pay \$100 deductible or have \$100 to \$200 deductible, and may pay 20% of Medi-care-approved charges or 20% to 100% of actual physicians charges.
Prescription Drugs	No coverage.	Nothing	Nothing/Some
Mammography	100% once every 2 years	Nothing	Nothing

*Medicare figures are as of January 1991. Contact Medicare at your nearest Social Security Administration office for the latest figures.

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